

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICESPRINTED: 10/30/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 505453	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 10/24/2013
NAME OF PROVIDER OR SUPPLIER KIN ON HEALTH CARE CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 4416 SOUTH BRANDON STREET SEATTLE, WA 98118		
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F 000	<p>INITIAL COMMENTS</p> <p>This report is the result of an unannounced Abbreviated Complaint Survey conducted on 10/24/13 at Kin On Health Care Center. A sample of 3 current residents from a total census of 92 was selected for review.</p> <p>The survey was conducted by: [REDACTED] MN, RN, Complaint Investigator</p> <p>Complaints investigated include: #2889325; 2894437</p> <p>The survey team is from: Department of Social and Health Services Aging and Long Term Support Administration Residential Care Services, District 2, Unit D 20425 72nd Avenue South, Suite 400 Kent, Washington 98032-2388</p> <p>Telephone: (253) 234-6000 Fax: (253) 395-5071</p> <p><i>Revised 10/30/2013</i> Residential Care Services Date</p>	F 000	<p>RECEIVED NOV 13 2013 OAH SEATTLE</p> <p>RECEIVED NOV 25 2013 JADE AIRCS Kent</p>		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

[Signature] CEO/Administrator 11/7/2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure a safe environment was maintained for a resident (#1) from a census of 92 with a known suicide risk. This placed the resident at risk of harm.</p> <p>Findings include:</p> <p>Observation and interview took place 10/24/13 unless otherwise noted.</p> <p>Record review found Resident #1 was admitted to the facility [REDACTED]/06 with multiple medically disabling conditions. Resident records identify the resident started receiving mental health services [REDACTED]</p> <p>Resident #1's minimum data set (MDS - an assessment tool) updated for significant change in condition 10/8/13 identified Resident #1 needed more assistance with activities of daily living than before and was now receiving continuous Oxygen (O2) via nasal cannula. The resident had [REDACTED] score of 15 (up from a score of 5 on the previous assessment). Resident #1's care plan identified</p>	F 323	<p>Kin On will ensure to provide each resident a safe and accident hazards free environment as possible and each resident will receive adequate supervision and assistance devices to prevent accidents by revising and updating the suicide prevention protocols.</p> <p>Mental Health consultant will conduct regular in-service training for nursing and social service staff to help staff to identify symptoms of depression, anxiety and warning signs of potential suicide attempts. Social Service Director has/will arrange such training. The first such training will be conducted on 11/20/2013. DNS will assure compliance.</p> <p>Social Service Director [REDACTED] has created a standardize check list for nursing staff to follow when staff has identified resident who has potential harm to self or others. Items on the checklist are designed to ensure safety of the resident and facilitate communication with members of the multi-disciplinary team. All nursing staff have been/or will be trained to utilize this checklist on 11/20/2013. Unit Coordinators are responsible for monitoring staff's compliance.</p>	<p>11/21/2013</p> <p>11/20/2013</p> <p>11/20/2013</p>

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F 323	<p>Continued From page 2</p> <p>interventions to encourage and assist the resident related to depression.</p> <p>On interview at 1:20 p.m., Resident #1's family member (FM) stated Resident #1 had experienced a decline in condition in the last month and had been overwhelmed coping with the changes and general physical discomfort. The FM stated in the past 2 weeks Resident #1 had twice made gestures to end her own life.</p> <p>The FM stated the first gesture was where Resident #1 attempted to choke herself with her own hands stating "I don't want to live like this". When the FM attempted to pull Resident #1's hands away from choking herself, Resident #1 grabbed the FM's hands, put them to her throat and said "please choke me!" According to the FM, about a week after the first incident, Resident #1 tried to tangle the O2 cord on her neck in an attempt to choke herself. The FM stated she told staff about both incidents at the time they occurred.</p> <p>Progress note review found on 10/12/13 Staff D documented family reported "she want to choke herself by holding her neck." Staff D documented staff would monitor the resident. On 10/12/13 Staff E documented the resident "squeezed her neck and asked her daughter to help to squeeze her to die." The resident was put on suicide watch, but no further interventions were made to the environment or adjustments to the plan of care.</p> <p>Records show Mental Health (MH) staff saw the resident 10/14 and 10/17/13 and documented "low mood and thoughts of dying". On 10/14/13 MH staff documented when asked if she would</p>	F 323	<p>Social Service Director has revised the Resident Daily Behavior Monitoring Form which provides a more accurate picture on resident's behavior and mood and facilitates communications among nursing and social service staff. Unit Coordinators will assure compliance. This action was/will be completed by 10/26/2013</p>	10/26/2013	

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F 323	<p>Continued From page 3</p> <p>harm herself, Resident #1 replied "I'm too weak."</p> <p>On 10/17/13 Staff F documented the resident had no other suicidal attempt, she only expressed "better die, I'm old" when discomfort was felt. Staff F documented the facility would remove sharp objects/long cords from Resident #1 and check frequently.</p> <p>On 10/17/13 the care plan was updated to include multiple interventions of observation, monitoring, assessment and referral related to thoughts and wishes of death. The care plan included "check resident regularly to monitor for risk of harming self or suicidal ideation/attempt." and "suicidal precaution - keep sharp objects or string away from her secure O2 cord/call light cord in shorten length."</p> <p>On 10/18/13 Staff G documented at 4:25 p.m. a FM reported the resident tried to use the O2 tubing to tie her neck, but was stopped from doing so by family. At this time the O2 cord and call light were shortened and immediate response made for suicidal gesture including having the resident agree to a "no harm" contract and immediate psychiatric evaluation.</p> <p>On interview at 4:45 p.m., Staff B (social services) stated she became aware of the first incident on 10/13/13 (one day later) when she read the nurse's notes as was her routine. Staff B stated she visited with Resident #1 on 10/13/13 and the resident seemed fine. Staff B arranged for mental health to see the resident the following day. According to Staff B, the first suicidal gesture on 10/12/13 was not as clear as the 10/18/13 gesture where Resident #1 attempted to use the O2 tubing to choke herself.</p>	F 323		

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F 323	Continued From page 4 On interview at 5:45 Staff A (director of nursing) stated staff did not implement interventions for the suicidal gesture/statements made 10/12/13 as they did not feel there was imminent risk of harm when the resident used only her hands to choke herself. Observation 10/24/13 at 1:20 p.m. found Resident sleeping soundly in bed, unresponsive to call or touch. The resident was turned to one side, a shortened Oxygen tube was secured to the bedframe in 3 places leaving no slack. The call bed was secured to the bed without slack. On interview at 1:20 p.m., Resident #1's family member (FM) stated the resident was no longer responsive after receiving [REDACTED] under Hospice care starting 10/22/13.	F 323			

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